BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ELIZABETH ALICIA ROBINSON** **336 Saclan Terrace** **Clayton, CA 94517** Registered Nurse License No. **613715** Respondent	Case No. 2011-905

DECISION AND ORDER

The attached Stipulated Surrender of License and Order is hereby adopted by the Board of Registered Nursing, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective on **August 23, 2011.**

- IT IS SO ORDERED **August 23, 2011.**

Jeannie K. Graves

President
Board of Registered Nursing
Department of Consumer Affairs
State of California

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ELIZABETH ALICIA ROBINSON** **336 Saclan Terrace** **Clayton, CA 94517** **Registered Nurse License No. 613715** Respondent.	Case No. 2011-905 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties in this proceeding that the following matters are true:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) is the Executive Officer of the Board of Registered Nursing. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Amanda Dodds, Senior Legal Analyst.

2. Elizabeth Alicia Robinson (Respondent) is representing herself in this proceeding and has chosen not to exercise her right to be represented by counsel.

3. On or about February 13, 2003, the Board of Registered Nursing issued Registered Nurse License No. 613715 to Elizabeth Alicia Robinson (Respondent). The Registered Nurse

License was in full force and effect at all times relevant to the charges brought in Accusation No. 2011-905 and will expire on December 31, 2012, unless renewed.

JURISDICTION

4. Accusation No. 2011-905 was filed before the Board of Registered Nursing (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on May 4, 2011. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation No. 2011-905 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, and understands the charges and allegations in Accusation No. 2011-905. Respondent also has carefully read, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel, at her own expense; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent admits the truth of each and every charge and allegation in Accusation No. 2011-905, agrees that cause exists for discipline and hereby surrenders her Registered Nurse License No. 613715 for the Board's formal acceptance.

9. Respondent understands that by signing this stipulation she enables the Board to issue an order accepting the surrender of her Registered Nurse License without further process.

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CONTINGENCY

10. This stipulation shall be subject to approval by the Board of Registered Nursing. Respondent understands and agrees that counsel for Complainant and the staff of the Board of Registered Nursing may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

11. The parties understand and agree that facsimile copies of this Stipulated Surrender of License and Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

12. This Stipulated Surrender of License and Order is intended by the parties to be an integrated writing representing the complete, final, and exclusive embodiment of their agreement. It supersedes any and all prior or contemporaneous agreements, understandings, discussions, negotiations, and commitments (written or oral). This Stipulated Surrender of License and Order may not be altered, amended, modified, supplemented, or otherwise changed except by a writing executed by an authorized representative of each of the parties.

13. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Registered Nurse License No. 613715, issued to Respondent Elizabeth Alicia Robinson, is surrendered and accepted by the Board of Registered Nursing.

1. The surrender of Respondent's Registered Nurse License and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent.

2. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

3. Respondent shall lose all rights and privileges as a Registered Nurse in California as of the effective date of the Board's Decision and Order.

4. Respondent shall cause to be delivered to the Board her pocket license and, if one was issued, her wall certificate on or before the effective date of the Decision and Order.

5. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 2011-905 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

6. Should Respondent's license be reinstated, she shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code section 125.3 in the amount of $9,720.50. Respondent shall be permitted to pay these costs in a payment plan approved by the Board. Nothing in this provision shall be construed to prohibit the Board from reducing the amount of cost recovery upon reinstatement of the license.

7. Respondent shall not apply for licensure or petition for reinstatement for two (2) years from the effective date of the Board of Registered Nursing's Decision and Order.

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ACCEPTANCE

I have carefully read the Stipulated Surrender of License and Order. I understand the stipulation and the effect it will have on my Registered Nurse License. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Registered Nursing.

DATED: 6-23-11

ELIZABETH ALICIA ROBINSON
Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Board of Registered Nursing of the Department of Consumer Affairs.

Dated: 6/30/2011

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
LINDA K. SCHNEIDER
Supervising Deputy Attorney General

AMANDA DODDS
Senior Legal Analyst
Attorneys for Complainant

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Exhibit A

Accusation No. 2011-905

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Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ELIZABETH ALICIA ROBINSON** **aka ELIZABETH ALICIA LOUGH** **aka ELIZABETH ALICIA HESSEN** **336 Sallan Terrace** **Clayton, CA 94517** **Registered Nurse License No. 613715** Respondent.	Case No. 2011-905 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about February 13, 2003, the Board of Registered Nursing issued Registered Nurse License Number 613715 to Elizabeth Alicia Robinson, also known as Elizabeth Alicia Lough, also known as Elizabeth Alicia Hessen (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2012, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 482 of the Code states:

> Each board under the provisions of this code shall develop criteria to evaluate the rehabilitation of a person when:
>
> (a) Considering the denial of a license by the board under Section 480; or
>
> (b) Considering suspension or revocation of a license under Section 490.
>
> Each board shall take into account all competent evidence of rehabilitation furnished by the applicant or licensee.

7. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions. . . .

8. Section 2762 of the Code states:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. . . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

REGULATORY PROVISIONS

9. California Code of Regulations, title 16, section 1443 states:

As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

10. California Code of Regulations, title 16, section 1443.5 states:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

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COSTS

11. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

12. Hydromorphone, also known by the brand name Dilaudid, is a Schedule II controlled substance as designated by Health and Safety Code Section 11055, subdivision (b)(1)(K), and is a dangerous drug pursuant to Business and Professions Code section 4022.

13. Morphine sulfate, sold under the brand name MS Contin, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M), and is a dangerous drug pursuant to Business and Professions Code section 4022.

FACTUAL ALLEGATIONS

14. Respondent was employed by John F. Kennedy Memorial Hospital (JFKMH) in Indio from May 17, 2004 to November 5, 2008. At all times relevant to the charges herein, Respondent was assigned to the cardiac catheterization laboratory[1] (or "cath lab") as an RN – Clinical III. Respondent was also a nursing instructor for Cal State San Bernardino and monitored students during their clinical rotations at JFKMH.

15. JFKMH's published policy entitled "Pyxis Medstation Management" states, in pertinent part, that (1) All Pyxis[2] User ID's and passwords are strictly confidential, failure to maintain confidentiality of Pyxis Medstation access can lead to disciplinary action; (2) The nurse will refer to the MAR and when necessary the original physician's written chart order to confirm

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[1] A catheterization lab is an examination room in a hospital or clinic with diagnostic imaging equipment used to support the catheterization procedure.

[2] "Pyxis" is a trade name for the automatic single-unit dose medication dispensing system that records information such as patient name, physician orders, the date and time the medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication. Each user/operator is given a user identification code to operate the control panel. Sometimes only portions of the withdrawn medications are administered to the patient. The portions not administered are referred to as "wastage." Wasted medications must be disposed of in accordance with hospital rules and must be witnessed by another authorized user and recorded in Pyxis.

medications to be removed from Pyxis for a specific patient; (3) Medications removed from Pyxis Medstation must be used immediately, returned if unopened or wasted. No medication removed from the Pyxis Medstation may leave the Hospital facility; (4) Medications will be wasted when a partial dose of a medication is administered to the patient, and the remainder is not utilized immediately (within 60 minutes); and (5) All wasted controlled substance medication will be documented and witnessed by two (2) state-licensed personnel.

16. JFKMH's published policy entitled "Administration of Medication" states, in pertinent part, that (1) All medication administered by nursing personnel will be documented in the Medication Administration Record (MAR); and (2) Document administration time (of medication) on the MAR immediately following administration. Medications are to be administered within a time frame of 30 minutes before or 30 minutes after scheduled administration time.

17. Respondent was trained in the above-referenced policies and this information was readily available to all JFKMH employees with access to Pyxis.

18. On or about November 5, 2008, an RN working in the JFKMH Medical-Surgical Unit went to Pyxis to remove Dilaudid to administer to her patient. According to Pyxis, Respondent had removed Dilaudid for the same patient at 12:05. Respondent, who was assigned to the Cath Lab, was not involved in the care of this patient. Respondent did not chart the administration of the Dilaudid in the patient's MAR. The RN telephoned Respondent who stated that she withdrew the medication, but got called away to the Cath Lab and was too busy to administer it. Respondent recorded in Pyxis that the dose of Dilaudid she withdrew at 12:05 was wasted at 12:56.

19. Upon receiving this report from the RN, the Nurse Director of the Cath Lab requested that the Pharmacy run an audit of Pyxis. The audit report revealed that on November 5, 2008, Respondent removed Dilaudid from Pyxis three separate times for patients who were not assigned for any Cath Lab procedures. The report further revealed that for each of Respondent's withdrawals of Dilaudid, she recorded that the waste was witnessed by an RN who was not working at JFKMH on November 5, 2008.

20. Respondent was interviewed by the interim Chief Nursing Officer, the Director of the Cath Lab, and a representative from the Human Resources Department. Respondent admitted to using another RN's Pyxis access code as a witness to her wastage, but stated that the RN voluntarily gave her the access code, and that it was common knowledge that RN's shared access codes. The RN in question was called at home and she denied giving her access code to Respondent. Respondent's employment was terminated by JFKMH on November 5, 2008.

21. As a result of Respondent's actions, an internal investigation was conducted by JFKMH. An audit of Respondent's Pyxis activity was conducted for the previous three months of Respondent's employment (August-September-October 2008). The report revealed that of the 229 times Respondent accessed Pyxis, 174 transactions appeared to be fraudulent. The fraudulent activity included instances where Respondent used another nurse's access code to witness wastage when that nurse was not working, the removal of Dilaudid without a physician's order, lack of documentation in the patients' MARs, and no wastage recorded. The following ten patient records are representative of discrepancies involving Respondent's handling of controlled substances:

22. Patient 1 (#467851): At 11:56 hours on October 7, 2008, Respondent removed 2 mg hydromorphone (Dilaudid) from Pyxis for this patient. There was no physician's order for hydromorphone. Respondent did not document its administration on the patient's MAR, and she did not record any wastage. Two mg hydromorphone was unaccounted for.

23. Patient 2 (#4676807): At 14:33 on October 7, 2008, Respondent removed one 4 mg dose of morphine and one 2 mg dose of hydromorphone from Pyxis for this patient. There was no order for either medication. At 14:50, Respondent wasted the 2 mg hydromorphone, and at 14:53 she wasted the 4 mg morphine. The waste was witnessed by an RN who did not work on October 7, 2008. Two mg hydromorphone and 4 mg morphine was unaccounted for.

24. Patient 3 (#4682939): At 18:57 on October 10, 2008, Respondent removed two 2 mg doses of hydromorphone from Pyxis for this patient. There was no physician's order for hydromorphone, and Respondent did not document its administration in the patient's MAR, nor did she record it wasted. Four mg hydromorphone was unaccounted for.

25. Patient 4 (#4620674): This patient had a physician's order for 1 mg hydromorphone. On October 13, 2008, at 11:40, Respondent removed 2 mg hydromorphone from Pyxis for this patient. Its administration was not documented in the patient's MAR and no waste was recorded. On October 14, 2008, Respondent removed 2 mg hydromorphone from Pyxis at 12:10 and recorded it wasted at 22:39 using the access code of an RN who did not work on October 14th. Respondent removed another 2 mg dose of hydromorphone at 18:12, and recorded 1 mg wasted at 22:37. The wastage was witnessed using the access code of a nurse who did not work on October 14th. The administration of 1 mg was not documented in the patient's MAR. On October 15, 2008, Respondent removed 2 mg hydromorphone at 14:48, and 2 mg hydromorphone at 17:45. The administration was not recorded in the patient's MAR, and there was no wastage documented. A total of 10 mg hydromorphone was unaccounted for.

26. Patient 5 (#4690168): This patient had an order for up to 2 mg hydromorphone. On October 13, 2008, Respondent removed 2 mg hydromorphone from Pyxis at 13:57. Its administration was not documented in the patient's MAR. The patient was located in another unit and did not have any Cath Lab procedures scheduled for October 13th. Two mg hydromorphone was unaccounted for.

27. Patient 6 (#4589542): On October 13, 2008, Respondent removed 2 mg hydromorphone from Pyxis for this patient at 15:08. The patient did not have an order for hydromorphone, Respondent did not document its administration in the patient's MAR, and there was no waste recorded. Two mg hydromorphone was unaccounted for.

28. Patient 7 (#4667352): On October 14, 2008, Respondent removed 2 mg hydromorphone from Pyxis for this patient at 13:39. The patient had an order for 1 mg hydromorphone. Respondent did not document its administration in the patient's MAR, and there was no waste recorded. Two mg hydromorphone was unaccounted for.

29. Patient 8 (#4692432): This patient did not have an order for hydromorphone and was not assigned to Respondent. On October 14, 2008, Respondent removed 2 mg hydromorphone from Pyxis at 16:33 and recorded it wasted at 2237 using the access code of an RN who did not work on October 14th. On October 23, 2008, Respondent removed 2 mg hydromorphone from

Pyxis at 20:47, and recorded it wasted the following day at 16:18. On October 24, 2008, Respondent removed 2 mg hydromorphone at 12:59, and recorded it wasted at 16:18. A minimum of 2 mg hydromorphone was unaccounted for.

30. Patient 9 (#4695941): This patient had an order for 2 mg morphine. On October 14, 2008, Respondent removed two 4 mg doses of morphine and one 2 mg dose of hydromorphone at 21:05. Neither dose was charted administered on the patient's MAR. On October 16, 2008, Respondent removed two 4 mg doses of morphine from Pyxis at 19:36. At 1939, Respondent wasted the 8 mg morphine using as a witness the access code of an RN who clocked out at 19:29. There was a total of 16 mg morphine and 2 mg hydromorphone unaccounted for.

31. Patient 10 (#4693191): This patient did not have an order for hydromorphone. On October 15, 2008, Respondent removed two 2 mg doses of hydromorphone from Pyxis at 11:43. On October 16, 2008, Respondent wasted 3 mg hydromorphone using the suspect access code. Respondent did not document any administration in the patient's MAR. A minimum of 1 mg hydromorphone was unaccounted for.

32. For the representative sampling of 10 patient records, Respondent was unable to account for a total of 29 mg hydromorphone, and 20 mg morphine.

33. On or about December 26, 2008, JFKMH filed a complaint with the Board alleging that Respondent was suspected of narcotics diversion. The matter was referred to the Division of Investigation (DOI).

34. In an interview with Respondent on October 7, 2010, Respondent admitted to the Division of Investigation that she used another nurse's Pyxis access code to document wastage of controlled substances. Respondent stated that it was a common practice among the nurses to share access codes and that "everyone did it." Respondent refused to provide the names of any other nurse who shared their access code. Respondent stated that she knew her actions were against hospital policy, but denied diverting controlled substances for her own use.

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FIRST CAUSE FOR DISCIPLINE

(Incompetence)

35. Respondent has subjected her registered nurse license to disciplinary action for unprofessional conduct under section 2761, subdivision (a)(1) in that she was incompetent, as defined by California Code of Regulations, title 16, section 1442, in that during the period from August 2008 to November 5, 2008, while employed by JFKMH (as detailed in paragraphs 14-34, above), Respondent repeatedly removed controlled substances from Pyxis and failed to properly document her handling of the narcotics in the hospital's MARs, medical records, or Pyxis. Respondent repeatedly failed to properly document wastage, she fraudulently used the Pyxis access code of another nurse to document waste, removed medication that was not ordered, and kept controlled substances in her personal possession without properly accounting for said medications. Respondent further withdrew medications for patients who were not assigned to her, and wasted medications outside the prescribed timeframe to do so. Respondent's actions demonstrated a repeated failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Illegal Possession of Controlled Substances)

36. Respondent has subjected her registered nurse license to disciplinary action under section 2762, subdivision (a) of the Code for unprofessional conduct in that on multiple occasions, as detailed in paragraphs 14-34, above, Respondent obtained and illegally possessed controlled substances taken from her employers.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Fraudulent Documentation in Hospital Records)

37. Respondent has subjected her registered nurse license to disciplinary action under section 2762, subdivision (e) of the Code for unprofessional conduct in that on multiple occasions, as described in paragraphs 14-34, above, Respondent intentionally falsified, or made grossly incorrect or grossly inconsistent entries in hospital, patient, and Pyxis records pertaining to controlled substances prescribed to patients.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 613715, issued to Elizabeth Alicia Robinson, also known as Elizabeth Alicia Lough, also known as Elizabeth Alicia Hessen;

2. Ordering Elizabeth Alicia Robinson to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 5/4/11

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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